

SECTION 10

FORMS

On the following pages are copies of various forms used by the Missouri Medicaid program.

Certain Medicaid programs, services, and supplies require the submission of a form before a claim can be processed for payment. Please note that several of the forms can be submitted electronically through the Infocrossing Internet service at www.emomed.com.

Acknowledgement of Receipt of Hysterectomy Information
Second Surgical Opinion
Sterilization Consent

If a form is submitted electronically, the provider **must** keep a paper copy of the form in the patient's medical record.

Copies of the forms are available from Medicaid from the following sources.

- Contact the Provider Communications Unit at 800/392-0938 or 573/751-2896.
- Go to the Medicaid website, www.dss.mo.gov/dms, and select and click on "forms" under Provider Information.
- Use the Infocrossing order form found at the end of this section.



STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES

PSYCHOLOGICAL SERVICES REQUEST FOR PRIOR AUTHORIZATION

Authorization approves the medical necessity of the requested service only. It does not guarantee payment. The recipient must be Medicaid eligible on the date of service.

RECIPIENT NAME (LAST, FIRST, M.I.)	DATE OF BIRTH	PROVIDER NAME (AFFIX LABEL HERE)
RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	MEDICAID NUMBER	ADDRESS
<input type="checkbox"/> INITIAL REQUEST <input type="checkbox"/> *CONTINUED TREATMENT		MEDICAID PROVIDER NUMBER

PROVIDER TELEPHONE NO.	PROVIDER FAX NO.	SIGNATURE	DATE
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- Has the patient/guardian agreed to his/her treatment plan? ☐ Yes ☐ No
- Have you communicated with the PCP or other relevant health care practitioners about treatment? ☐ Yes ☐ No ☐ No Release ☐ No PCP
- Are you requesting Family Therapy be conducted? ☐ Yes Provider# _____ ☐ No
- Are you requesting Group Therapy be conducted? ☐ Yes Provider# _____ ☐ No
- Are you requesting assessment hours? ☐ Yes Hours _____ ☐ No
- Are you requesting diagnostic testing? ☐ Yes Hours _____ ☐ No

DSM-IV-TR MULTIAXIAL DIAGNOSIS (PLEASE COMPLETE)

AXIS I: CLINICAL DISORDERS OR OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTIONS

DIAGNOSTIC CODE	DIAGNOSTIC CODE
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IS THERE ANY EVIDENCE OF SUBSTANCE ABUSE?

☐ Yes ☐ No

AXIS II: PERSONALITY DISORDERS, MENTAL RETARDATION

DIAGNOSTIC CODE	DIAGNOSTIC CODE
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AXIS III: GENERAL MEDICAL CONDITIONS

DOES THIS PATIENT HAVE A CURRENT GENERAL MEDICAL CONDITION THAT IS POTENTIALLY RELEVANT TO THE UNDERSTANDING OR MANAGEMENT OF THE CONDITION(S) NOTED IN AXIS I OR II?

☐ Yes ☐ No If Yes, list condition: _____

AXIS IV: PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS (PLEASE INDICATE ALL THAT APPLY)

- | | |
|--|--|
| <input type="checkbox"/> Problems with primary support group | <input type="checkbox"/> Economic problems |
| <input type="checkbox"/> Problems related to social environment | <input type="checkbox"/> Educational problems |
| <input type="checkbox"/> Problems with access to health care services | <input type="checkbox"/> Occupational problems |
| <input type="checkbox"/> Other psychosocial and environmental problems | <input type="checkbox"/> Housing problems |
| <input type="checkbox"/> Problems related to interaction with legal system/crime | <input type="checkbox"/> None |

AXIS V: GLOBAL ASSESSMENT OF FUNCTIONING SCALE (GAF)

SCORE	DATE
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SERVICE INFORMATION								FOR STATE USE ONLY	
(This area to be used only if the patient is between the ages of 0-2 or if Family Therapy without the patient present)								APPROVED	DENIED
REF. NO.	PROCEDURE CODE	MODIFIER 1	MODIFIER 2	FROM	THROUGH	DESCRIPTION OF SERVICE/ITEM	QTY. OR UNITS		
1									
2									
3									

* Requires an initial assessment, treatment plan and the last three progress notes. Continued treatment requests may only be made after 75% of the current PA is used.

MO 886-4140 (9-04)

INSTRUCTIONS FOR COMPLETION

HEADER INFORMATION

Recipient Name – Enter the recipient's name as it appears on the Medicaid ID card.

Date of Birth – Enter the recipient's date of birth.

Provider Name – Attach a Medicaid provider label or enter the requested provider's information exactly as it appears on the label.

Recipient Address – Enter the recipient's current address.

Medicaid Number – Enter the recipient's 8-digit Medicaid identification number as shown on the Medicaid identification card or county letter of eligibility.

Provider Address – If a Medicaid provider label is not used, enter the complete mailing address in this field.

Initial Request/Continued Treatment – Mark *Initial* for the first Prior Authorization (PA) requested after the 4 hours service without PA. Mark *Continued Treatment* for any PA requested after the initial PA. After the initial/first PA, the second and all future requests require copies of the original assessment, the treatment plan, and the last three progress notes attached to the Prior Authorization Request Form.

Medicaid Provider Number – If a Medicaid provider label is not used, enter the provider's Medicaid Identification number.

Provider Phone – Enter current phone number of the provider making the request.

Provider Fax Number – Enter the fax number of the provider making the request.

Signature/Date – The provider of services should sign the request and indicate the date the form was completed.

QUESTIONS NUMBER 1 THROUGH 6 MUST BE COMPLETED. A SEPARATE PA MUST BE REQUESTED FOR NUMBERS 3 AND 4. HOURS FOR ASSESSMENT AND DIAGNOSTIC TESTING MUST BE LISTED IN ORDER TO BE REIMBURSED.

DSM-IV-TR MULTIAXIAL DIAGNOSIS MUST BE COMPLETED

Axis I – Clinical Disorders

Axis II – Personality Disorders, Mental Retardation

Axis III – General Medical Conditions

Axis IV – Psychosocial and Environmental Problems

Axis V – Global Assessment of Functioning

SERVICE INFORMATION – This field is only to be used for psychological services for children under 3 years of age and Family Therapy without Patient Present.

- 1). Ref. No. – (Reference Number) A unique designator (1-4) identifying each separate line on the request.
- 2). Procedure Code – Enter the behavioral therapy procedure code being requested here.
- 3). Modifier 1 and Modifier 2 – If appropriate, enter the modifier that goes with the corresponding procedure code here.
- 4). From – Enter the from date that service will begin if authorization is approved (mm/dd/yy format).
- 5). Through – Enter the through date that the service will terminate if authorization is approved (mm/dd/yy format).
- 6). Description of Service/Item – Enter a specific description of the service/item being requested.
- 7). Quantity or Units – Enter the quantity or units of service/item being requested.

STATE USE ONLY – Leave Blank

Prior authorization request may be phoned, faxed or mailed into the call center (see below)

Verizon
P.O. Box 4800
Jefferson City, MO 65102
Phone (toll free) 866-771-3350
Fax 573-635-6516



MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
MISSOURI MEDICAID INSURANCE RESOURCE REPORT

TPL-4

Submit this form to notify the Medicaid agency of insurance information that you have verified for a Medicaid recipient. Please send the completed form to:

Department of Social Services
Division of Medical Services
Attention: TPL Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

DO NOT SEND CLAIMS WITH THIS FORM. YOUR CLAIM WILL NOT BE PROCESSED FOR PAYMENT IF ATTACHED TO THIS FORM.

PROVIDER IDENTIFICATION NUMBER

DATE (MM / DD / YY)

PROVIDER NAME

CHECK THE APPROPRIATE BOX FOR THE REQUESTED ACTION



ADD NEW RESOURCE

OR



CHANGE MEDICAID RESOURCE FILES

RECIPIENT NAME

MEDICAID I.D. NUMBER

INSURANCE COMPANY NAME

POLICYHOLDER (IF OTHER THAN RECIPIENT)

POLICYHOLDER'S SOCIAL SECURITY NUMBER

POLICY NUMBER

GROUP NAME OR NUMBER

VERIFIED INFORMATION

SOURCE OF VERIFIED INFORMATION:



EMPLOYER



INSURANCE COMPANY

TELEPHONE NUMBER OF CONTACT

DATE CONTACTED (MM / DD / YY)

()

NAME OF PERSON COMPLETING THIS FORM

TELEPHONE NUMBER

Do you want confirmation of this add/update?

(If yes, you must complete the name and address on back)



YES



NO

ATTACH A COPY OF AN EXPLANATION OF BENEFITS OR INSURANCE LETTER IF AVAILABLE

TO BE COMPLETED BY THE PROVIDER

If confirmation of this add/update is requested, please write the name and address of the person the confirmation should be sent to below. The TPL Unit will complete the bottom portion of this form and mail to the address shown.

TO BE COMPLETED BY THE STATE

☐ Verification and correction as requested completed Date: _____

Insurance Begin Date: _____ Insurance End Date: _____

☐ Please resubmit claims

☐ Form not complete enough for verification by state - complete highlighted areas and resubmit

☐ TPL file already reflects the add/update. Our records were updated: _____

☐ Verification confirms Medicaid resource file correct as is - no update performed

☐ Change requested cannot be made. Reason:

☐ Verification shows another current coverage that may be applicable:

☐ Other: _____



MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

APPLICATION FOR PROVIDER DIRECT DEPOSIT

PLEASE TYPE OR PRINT IN BLACK INK		***SEE INSTRUCTIONS ON REVERSE SIDE***	
SECTION A (All providers must complete this section)			
1. TYPE OF DIRECT DEPOSIT ACTION ➡ <input type="checkbox"/> New provider/Re-enrollment <input type="checkbox"/> Cancel Direct Deposit <input type="checkbox"/> Change Account/Route number			
2. PROVIDER NAME: Complete provider name below as shown on provider labels. If the Application for Provider Direct Deposit is for a clinic or group, this form must be accompanied by an Authorization by Clinic Members which must contain a list of the provider name(s) and number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic/group, along with the ORIGINAL signature of the clinic owner or administrator. All other providers MUST complete a separate Application for Provider Direct Deposit containing their individual provider number and original signature. The clinic Application for Provider Direct Deposit will not be processed without the completed Authorization by Clinic Members. A separate Application for Provider Direct Deposit must be completed for each provider number assigned.			
TYPE OR PRINT PROVIDER NAME HERE ➡ _____			
3. PROVIDER NUMBER (enter provider number as shown on provider label, one provider number per application) _____			
SECTION B (Complete this section if you wish to enroll in direct deposit OR a change in account/route number(s) is requested.) (ATTACH a voided check showing the routing/account numbers, OR if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution completed below. The information completed on this form and the information on the attachment MUST match.)			
1. ROUTING NUMBER _____	2. DEPOSITOR ACCOUNT NUMBER _____		
3. TYPE OF ACCOUNT (must check one) ➡ <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS			
4. FINANCIAL INSTITUTION NAME _____	5. BRANCH NUMBER OR NAME (if applicable) _____		
6. FINANCIAL INSTITUTION ADDRESS _____	7. TELEPHONE NUMBER (include area code) _____		
SECTION C			
I wish to participate in Direct Deposit and in doing so:			
<ul style="list-style-type: none"> ◆ I understand that in endorsing or depositing checks that payment will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State laws. ◆ I hereby authorize the State of Missouri to initiate credit entries (deposits) and to initiate, if necessary, debit entries (withdrawals) or adjustments for any credit entries made in error to my account designated above. ◆ I understand that the State of Missouri may terminate my enrollment in the Direct Deposit program if the State is legally obligated to withhold part or all payments for any reason. ◆ I understand that the Division of Medical Services may terminate my enrollment if I no longer meet the eligibility requirements. ◆ I understand that this document shall not constitute an amendment or assignment, of any nature whatsoever, of any contract, purchase order or obligation that I may have with an agency of the State of Missouri. 			
I am authorized to request Direct Deposit on behalf of this clinic/group and in doing so:			
<ul style="list-style-type: none"> ◆ I acknowledge that each individual in the clinic/group listed on the attached Authorization by Clinic Members has been informed of this request, and also informed that Medicaid funds will be sent to the depositor account specified above. ◆ I understand that each individual provider is responsible for all services provided and all billing done under the individual or clinic provider number, regardless to whom the reimbursement is paid. It is each individual provider's responsibility to use the proper billing code and indicate the length of time actually spent providing a service, regardless to whom the reimbursement is paid. 			
1. <input type="checkbox"/> I HEREBY CANCEL MY DIRECT DEPOSIT AUTHORIZATION and authorize future payments to be sent to the current payment name and address recorded in the provider enrollment file. (Section A number 1 must also be completed)			
2. PROVIDER ORIGINAL SIGNATURE (see requirements on reverse side of this form)	TYPE OR PRINT NAME SIGNED & TITLE	3. DATE	4. TELEPHONE NUMBER
RETURN ORIGINAL FORM (and original Authorization by Clinic Members, if applicable) ALONG WITH A VOIDED CHECK OR LETTER FROM YOUR BANK (see Section B) TO: Division of Medical Services, Provider Enrollment Unit, PO Box 6500, Jefferson City MO 65102. Phone 573-751-2617			

THIS FORM CANNOT BE FAXED

APPLICATION FOR PROVIDER DIRECT DEPOSIT INSTRUCTIONS

SECTION A ***ALL providers must complete this section***

- 1. Type of Direct Deposit Action** - Check appropriate box. **If canceling direct deposit you must also complete Section C, #1.**
2. & 3. Provider Name and Provider Number - Enter provider name and number **EXACTLY** as shown on your provider label.

SECTION B ***This section must be complete for new applicants or re-enrollments and any changes to your direct deposit information.

ATTACH a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form**. The information completed on this form and the information on the attachment **MUST** match.

- 1. Routing Number** - Enter your financial institution's routing number as printed on the bottom left portion of your business checks or deposit tickets (the first 9 digits). See Examples 1 and 2 below.
- 2. Depositor Account Number** - Enter depositor account number as printed on the bottom of business checks following the routing number. It may be the first series of digits after the routing number followed by your check number (example 1) or it may be the series of digits which follow your check number (example 2). NOTE: The check number is not included in the depositor account number.

EXAMPLE 1

FINANCIAL INSTITUTION HOMETOWN, USA		CHECK NO. 4444
PAY TO ORDER OF _____		
121456789	8765432109812	4444

EXAMPLE 2

FINANCIAL INSTITUTION HOMETOWN, USA		CHECK 4444
PAY TO ORDER OF _____		
121456789	4444	8765432109812

↑ ↑ ↑
 Routing No. Depositor Acct No. Check No.

↑ ↑ ↑
 Routing No. Check No. Depositor Acct No.

*****Credit Unions and Savings and Loan Associations may differ from the above examples. Please VERIFY your DEPOSITOR ACCOUNT NUMBER and ELECTRONIC ROUTING NUMBER with your financial institution.*****

SECTION C

- 1. TO CANCEL OR REDESIGNATE:** Complete and submit a new Application for Provider Direct Deposit with the changed information and forward to the Division of Medical Services. **You must check the CANCEL box if you wish to CANCEL your direct deposit, Section A number 1 must also be completed.** If you elect to cancel direct deposit future payments will be sent to the current payment name and address recorded in the provider enrollment file. Provider direct deposits will continue to be deposited into the designated account at your financial institution until the Division of Medical Services is notified that you wish to **cancel or redesignate** your account and/or financial institution.
DO NOT CLOSE AN OLD ACCOUNT UNTIL THE FIRST PAYMENT IS DEPOSITED INTO YOUR NEW ACCOUNT.
- 2. PROVIDER SIGNATURE** - If the provider is enrolled as an individual, he/she must sign the form. Nursing homes, hospitals, independent laboratories and home health agencies must be signed by a person listed on form HCFA-1513 (disclosure of ownership) section III (a). If enrolled as a clinic or business (except those listed above) the form must be signed by the person with fiscal responsibility for the same. **Clinic applications must be accompanied by the Authorization by Clinic Members which must contain a list of the name(s) and provider number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic location. The Application for Provider Direct Deposit and the Authorization by Clinic Members MUST be signed by the same person. All other providers must complete a separate Application for Provider Direct Deposit containing their individual provider number and original signature. A SEPARATE FORM MUST BE COMPLETED FOR EACH PROVIDER NUMBER ASSIGNED.**

OTHER

- 1. ATTACH** a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form**. The information completed on this form and the information on the attachment **MUST** match.
- Direct deposit will be initiated after a properly completed application form is approved by the Division of Medical Services and the successful processing of a test transaction through the banking system.
- This form must be used to change** any financial institution information **or to cancel** your election to participate in direct deposit.
- The Division of Medical Services will terminate or suspend the direct deposit option for administrative or legal actions including, but not limited to, ownership change, duly executed liens or levies, legal judgements, notice of bankruptcy, administrative sanctions for the purpose of ensuring program compliance, death of a provider and closure or abandonment of an account.
- If any information completed on this form cannot be verified from the attachments or the form is completed incorrectly, the form(s) will be returned without being processed for direct deposit.

Forms Request

Provider Number: _____
(Or Affix Provider Label Here)

Date: _____

Provider Name: _____

Provider Phone: _____

CLAIM FORMS	Quantity	
	Preprinted	Blank
A. Pharmacy		
B. Dental		
C. HCFA 1500 (Rev 12/90)		
D. HCFA 1450 (UB-92) Inpatient / Outpatient/ Home Health		
F. Prior Authorization		

CROSSOVER STICKERS

G. Hospital Crossover Sticker (BLACK)	
H. SNF Crossover Sticker (RED)	
I. Part B Crossover Sticker (BLUE)	

If provider labels are needed with blank Claim Forms (A-F), check box. ☐

If you checked box, an equal number of labels will be supplied with Forms A-F. If you DID NOT check box, you WILL NOT receive labels.

If provider labels are needed and you are not ordering Forms A-F, indicate the quantity _____

SPECIAL MAILING INSTRUCTIONS:

Name: _____

Attn: _____

Street Address: _____

(Not P.O. Box)

City: _____

State: _____ Zip: _____

ADDRESS CHANGE / CORRECTION:

Provider Number: _____

Name: _____

Street Address: _____

(Not P.O. Box)

City: _____

State: _____ Zip: _____

Effective Date of Change: _____

ATTACHMENTS

Quantity

J. HCY Medical Screening Tool (All Pages)	
HCY Screening Forms by Age Group	
2. Newborn - 1 month/2 - 3 months	
3. 4 - 5 months/6 - 8 months	
4. 9 - 11 months/12 - 14 months	
5. 15 - 17 months/18 - 23 months	
6. 24 months/3 years	
7. 4 years/5 years	
8. 6 - 7 years/8 - 9 years	
9. 10 - 11 years/12 - 13 years	
*. 14 - 15 years/16 - 17 years	
&. 18 - 19 years/20 years	
K. HCY Lead Risk Assessment Guide	
L. Sterilization Consent	
M. Acknowledge Hysterectomy	
O. Hearing Aid Evaluation	
P. Medical Necessity	
Q. Adjustment Request	
R. Medical Necessity Long Term HPN	
S. Second Surgical Opinion	
T. Medical Necessity - Abortion	
U. Hospice Election Statement	
V. Oxygen - Respiratory Justification	
W. Notification of Termination of Hospice Benefits	
Y. Insurance Resource Report (TPL-4)	
Z. Accident Reporting Form (TPL-2P)	
1. Physician Certification of Terminal Illness	

* Provider Signature: (Must Be Provider's Original Signature)

All requests are delivered to the address on your current provider label unless an address change or correction is requested above. An address change or correction changes your provider billing label. If Special Mailing Instructions are indicated, this and all future requests for forms from Verizon Data Services are delivered to this address until notice of a change is received. A change to Special Mailing Instructions does not change your provider billing label.

The above forms are provided to all participating Missouri Medicaid Providers. They are intended solely for Missouri Medicaid claims filing. Please complete the above information and return it to Verizon Data Services via any paper claims submission P.O. Box. For information regarding electronic claims submission, contact Verizon Data Services at (573) 635-3559.

DS1054 (Rev. 11/00)

NONDISCRIMINATION POLICY STATEMENT

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS shall take affirmative action to ensure that employees, applicants for employment, clients, potential clients, and contractors are treated equitably regardless of race, color, national origin, sex, age, disability, religion, or veteran status.

All DSS contracts and vendor agreements shall contain non-discrimination clauses as mandated by the Governor's Executive Order 94-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended/ the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability or religion may file a complaint by calling the DSS Office for Civil Rights at 1-800-776-8014. Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services
Office for Civil Rights
P. O. Box 1527
Jefferson City, MO 65102-1527

Or

U.S. Department of Health and Human Services
Office for Civil Rights
601 East 12th Street
Kansas City, MO 64106

Additionally, any person who believes they have been discriminated against in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the United States Department of Agriculture at:

USDA Office of Civil Rights
1400 Independence Ave., SW
Mail Stop 9410
Washington, DC 20250

This policy shall be posted in a conspicuous place, accessible to all applicants for services, clients, employees, and applicants for employment, in all divisions, institutions and offices governed by DSS.



Director, Department of Social Services

2004
Year